Mental Health
Review Tribunal

NSW MENTAL HEALTH REVIEW TRIBUNAL SUBMISSION

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

Summary of consultation meeting with LRC

on 24 October 2012

provided on 5 February 2013

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. In October 2012, the Tribunal was invited to meet with the Law Reform Commission to discuss a number of issues arising out of the submission to the Commission in July 2012. This submission summarises the Tribunal's position in relation to the issues discussed at that meeting.

1. Risk of harm

Currently, the Act deals with risk of harm to the public (and the forensic patient) in a number of ways.

Court orders

Following a finding of NGMI:

(2) The Court is not to make an order under this section for the release of a person from custody unless it is satisfied, on the balance of probabilities, that the safety of the person or any member of the public will not be seriously endangered by the person's release.

Question 1

(1) Do any practical problems arise due to the courts' decision to detain or release?

(2) Should the test be reframed in any way?

Question 1(1)

Sections 24 and 39 of the MHFPA allow a Court to order the detention of a person wherever the court considers appropriate. Courts sometimes order that a person be detained in a mental health facility. The Tribunal is aware of real practical difficulties in complying with court orders of this kind. In particular, it is rare for a bed to be available in a mental health facility, unless the person being sentenced is already the occupant of that bed. As a result, people who are ordered to be detained in a mental health facility will often, nonetheless, spend a period of time in a correctional setting.

A sentencing court is also able to make an order for conditional release. The Tribunal has two concerns about orders of this kind being made by a court. First, the court is less likely to have access to high quality, impartial information regarding the

risk posed by an individual, the level of support required to safely manage that risk, and whether those services are available for the individual. This is the kind of information which the Tribunal requires when ordering a person's conditional release so as to tailor the conditions of release to the particular needs and circumstances of the individual.

The Tribunal's second concern about a court ordered conditional release is that the person may not (at the time of the court order) have been linked into the community mental health services. The delay in connecting a person to the appropriate community support is often a time of high risk for the patient, and therefore for the community.

The Tribunal considers that it would be appropriate for the a court to have regard to same range of issues set out in ss 43, 47 and s75 of the MHFPA before deciding to conditionally release a person.

Despite the low numbers of people released by the court the Tribunal is aware of a number of incidents where individuals who have been conditionally released have committed serious act of violence or where there has been significant deterioration in the person's condition within a very short time from the court ordering the person's conditional release.

See more generally Submission of July 2012, p13

Question 1(2)

For the reasons outlined in answer to question 3 below, the Tribunal considers that if the only risk posed by a forensic patient is to him/herself then the person should be treated as a civil patient, rather than a forensic patient. The Tribunal considers that s. 39(2) should be amended so as to remove the reference to a risk to self.

In those circumstances, it would be appropriate for court to have the power to refer a person to a mental health facility for assessment when making an order for unconditional release in respect of someone whom the court considers would pose a risk of harm to themself. Practically, there may also be a need for a court liaison service to make the link between the court and the health sector.

Question 2

(1) Is the safety of the community addressed appropriately in the MHFPA? Do any problems arise and can it be improved?

(2) Should the presumption in favour of detention be reversed – for example:

> unless the MHRT considers the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released, the MHRT must release the supervised person conditionally/unconditionally?

Question 2(1)

The Tribunal is of the opinion that the legislation is presently adequate to address the safety of the community. The risk posed to the safety of the community arises more from practical issues, such as the sharing of information; and the level of funding and resources available in mental health facilities, correctional centres and the community.

Question 2(2)

The Tribunal considers that the onus should not be reversed. In a forensic context, there is a demonstrated risk posed to the community when a patient is mentally unwell. This is in contrast to the risk assessment process which is undertaken in a civil context, where the risks are usually more theoretical.

Forensic patients have often had previous contact with the civil mental health system and either not able to be managed by the civil mental health system; or were non-compliant at the time of the index event. It is important for both the patient and the community that the Tribunal is satisfied that a patient's risk is being well managed before the patient is released.

Transfer to the civil mental health system

Stakeholders have submitted that where forensic patients only present a risk of harm to themselves, they should be transferred to the civil mental health system.

Question 3
Do any issues arise in relation to this?

Question 3

As noted above, if the only risk posed to a forensic patient is to the patient themself, (rather than the community at large) then it is appropriate that the patient be managed under the civil system. The civil system provides for a higher standard to be met before forcibly treating an individual. If the only risk posed by a person's illness is to the person themself, then that higher standard should be applied.

Question 4
(1) Do practical problems arise due to the length of the limiting term imposed by the court? Is there a better way of setting the time limit?
(2) How often are people released before the limiting term? Is it common for people to be unconditionally released prior to the expiry of their limiting term?

Question 4(1)

The Tribunal's comments in relation to the calculation of a limiting term, and more fundamentally, the purpose of imposing a limiting term, are set out on p 14 of its submissions made in July 2012.

The other practical difficulties associated with the care and treatment of patients on limiting terms occur when a person has, for example an intellectual disability or personality disorder, but does not have a mental illness. Consequently, a person may pose a serious risk to the community at the expiration of that limiting term, and yet cannot continue to be detained under the MHA. The Tribunal's submission made in July 2012 at p 23 and in Attachment 1 sets out the Tribunal's proposal for an amendment to the MHFPA to address this issue.

Question 4(2)

The Tribunal does not know of any patients who have been unconditionally released before the end of their limiting term.

Conditional release prior to the end of a limiting term is rare. The Tribunal is currently considering three applications, and is being assisted in its decision by legal submissions made on behalf of the Attorney General and the patient.

The Tribunal's records show that one fifth (10 out of 54) patients have continued to be detained in a mental health facility under the MHA after the expiry of their limiting term.

Question 5

Are forensic patients with cognitive impairment or complex needs appropriately handled within the forensic system?

(a) How are people with cognitive impairment (and no mental illness) generally managed?

(b) What expertise does the MI IRT have and how does it deploy this expertise in relation to defendants with cognitive impairment?

(c) Should the name of the MHRT be changed to reflect its dual expertise?

Question 5

While the vast majority of forensic patients (90% or so) have a primary diagnosis of mental illness, there is a high rate of co-morbidity with other diagnoses, such as: drug and alcohol (55%); personality disorder (16%); head injury; cognitive difficulties arising from prolonged mental illness; intellectual disability; or aged related issues such as dementia. There are about 387 forensic patients in NSW, yet only about 10 have only an intellectual disability.

At present the Tribunal understands that only those who meet the ADHC criteria are classified as having a cognitive impairment, which is a narrower definition than that posited by the LRC.

There are deficiencies in the management of those patients with a cognitive impairment and not a mental illness. They are generally detained in prison. Suitable programs are generally limited to those housed within specialised units. However, Corrective Services NSW has established a Personality and Behavioural Disorders Unit which is based at Long Bay Hospital and which also offers ambulatory care to those in other correctional centres.

The Tribunal is also aware of an increasing number of prisoners who have dementia and other psycho-geriatric issues.

See further p 20 of July 2012 submission.

The MHRT has amongst its members, expertise in cognitive impairments who sit on forensic matters. Under the s. 73(2) of the MHFP Act, the Tribunal's panel could be comprised of a (Deputy) President; a registered psychologist or other suitable expert in relation to a mental condition (instead of a psychiatrist); as well as another suitably qualified member. The Tribunal is considering constituting panels with two experts in cognitive impairment, particular if the Tribunal is considering an application for conditional release for a patient to enter a CJP and whose only diagnosis is intellectual disability.

While individuals with a cognitive impairment do come under review by the Tribunal, the vast majority of the work of the Tribunal relates to mental illness and the Tribunal's jurisdiction is conferred by mental health legislation. The present name is appropriate.

4. Breach of conditions of leave or release

The MHRT noted that it has requested amendment of breach provisions to ensure that breach of orders are managed in a similar way to breach of a CTO, that is:

....

Question 6

What issues do these suggested changes address?

Question 6

The answer to this question is addressed in the Tribunal's response to the question 15 posed by the LRC in January 2013.

See also p 22 of July 2012 submission.

5. Supporting agencies

The MHRT noted that it would be beneficial to be able to "specifically require certain assessments [to] occur by imposing conditions on the services managing the forensic patient while on leave or release".

Question 7

How would this be enforced?

Question 7

The answer to this question is addressed in the Tribunal's response to the question 8 posed by the LRC in January 2013.

Question 8

Are the information sharing provisions in the MHFPA insufficient? Could the issues you raise be addressed through agreements with relevant agencies and/or the consent of forensic patient?

Question 8

The Tribunal is aware of situations where a treating team is not able to obtain the information that it needs to effectively treat a patient, as another Local Health District refuses to provide that information because of privacy concerns. In other instances, justice agencies and health agencies will not exchange the information they each hold about the same patient. One example is in the case of co-offenders who are both forensic patients and whose offence involved a "folie a deux". The management of the risk of these co-offenders is contingent on the exchange of information between the teams treating each offender.

The Tribunal considers that there should be a general exception to the privacy regimes to allow for the exchange of information between agencies (including health and justice agencies) involved in the care, treatment and management of forensic patients. It would not be possible to rely on the consent of the forensic patient as the patient may not have capacity to consent and/or may refuse to give that consent.

See p23 submission of July 2012

Question 9
Are forensic patients subject to compulsory treatment without their consent in circumstances where they would not have been subject to compulsory treatment as an involuntary patient under the civil mental health system?

Question 9

Many forensic patients held in mental health facilities would not meet the criteria for detention under the MHA. However, as discussed above, a forensic patient has demonstrated an actual (as opposed to theoretical) risk to others when mentally unwell. As such, it is appropriate to continue to require coerced engagement with mental health services to improve their mental health, insight into the need for treatment, and address related rehabilitation goals in order for them to safely re-enter the community.

It is worth noting that the Ministry of Health have their own protocols which prohibit the physical imposition of treatment, such as forced injections, except in very specific

circumstances. The sort of “involuntary treatment” to which most forensic patients are subjected is no more than a refusal to grant leave or privileges if the person will not accept their medication.

Question 10

(1) Are you aware of how many people are conditionally released following a finding of UNA? If so, do you know what sentencing option is generally applied?

(2) Is there any reason that this group should not also be classified as forensic patients?

Question 10

If, under s.23(2) of the MHFP Act, the Court imposes a penalty other than a limiting term (for example, a s.9 bond) the person does not become a forensic patient and the Tribunal does not hold any records in relation to them.

A person who is found NGMI following a special hearing is able to be conditionally released by the Court and then becomes a forensic patient. The person’s care treatment and control are then reviewed by the Tribunal. The Tribunal can see no reason to distinguish between people found NGMI and those found UNA (but not sentenced to a limiting term). The Tribunal considers that it would be appropriate that a court be able to conditionally release a person who has been the subject of a finding of UNA, and that the Tribunal have jurisdiction to review their conditional release for a finite period.

See July 2012 submission pp 13 and 15

Question 11

(1) Where are people being detained by the court under s 27 of the MHFPA? Where a person is not detained in a mental health facility, are there any options other than prison?

(2) Is this working well?

Question 11

At present, the only places of detention are a prison or a mental health facility.

It is conceivable that a Court could order that a person be detained in a secure nursing home. There are forensic patients with advanced dementia that are currently accommodated in nursing homes, but to date this has been done pursuant to conditional release order. However, before a person were ordered to be detained in a nursing home, there would need to be real attention paid to the security available at that nursing home and its capacity to manage the risk associated with forensic patients, whose cognitive condition is deteriorating. The Tribunal is not aware of any other facilities in NSW that are presently able to securely detain individuals. However, the Tribunal understands that other jurisdictions (such as Queensland) do have separate units to detain patients with complex needs (but who may not have a mental illness). The possibility of constructing such facilities in NSW is being canvassed. The Forensic Mental Health Network may be able to provide further information on these issue.

Other related issues are that, first, courts will not always make an order in relation to the person's place of detention under s. 27, which creates confusion.

Secondly, even when a court order is made to detain a person in a mental health facility, it is rare that a bed is immediately available, unless the person is already occupying a bed. In that case, the person is usually detained in a prison until a bed does become available and the wait may be lengthy. This is a major systemic problem which often frustrates the Tribunal's capacity

Question 12

(1) What orders are being imposed by the court following a finding of NGMI?

(2) Do any difficulties arise with the conditions imposed by courts on conditional release orders?

(3) Do any difficulties arise with orders by courts for detention in a mental health facility (or other place)?

Question 12(1)

Year	No. Found NGMI and Ordered to be Detained	No. Set Limiting term and ordered to be detained	No. Found NGMI and Conditionally Released by the Court[1]
1990	3		
1991	8	0	
1992	14	1	
1993	6	0	
1994	17	0	
1995	7	3	
1996	11	3	
1997	11	1	
1998	18	1	
1999	31	3	
2000	25	3	
2001	21	1	
2002	28	7	
2003	13	8	
2004	11	6	1
2005	11	3	4
2006	13	5	3
2007	9	4	5
2008	24	9	10
2009	25	6	7
2010	24	4	6
2011	20	6	6

Question 12(2)

For the reasons outlined above, the Tribunal is aware of practical problems with court ordered conditional release.

See also pp 13 -15 of July 2012 submission.

Question 12(3)

As noted above, even when a court orders that a person be detained in a mental health facility, it is rare that a bed will be immediately available, unless the person is already occupying that bed.

1 In 2003 the Courts received the power to release those found not guilty by reason of mental illness direct from Court.

9. Notification requirements

The MHRT must inform the Minister for Police, the Minister for Health and the Attorney General of any order it makes for the release of a forensic patient, including the date of release. In submissions, some stakeholders that responded to this issue noted that notification of the Minister for Police is not required, as the Minister has no power to appeal release decisions.

Question 13

Is notification of the Minister for Police necessary? If so, why?

Question 13

The Tribunal understands that the rationale for notifying the Minister for Police is not to allow the exercise of appeal rights, but to ensure the safe management of the forensic patient in the community. That is, if the person were to be arrested by police, the NSW Police would be on notice and able to notify the Tribunal is notified as soon as possible, and/or take appropriate measures to have the person assessed.

However, that purpose may be better served by amending the MHFP Act so that the Commissioner of Police is notified, in lieu of the Minister for Police.

10. Arrangements for continuing care

Prior to releasing a forensic patient from a mental health facility, the "authorised medical officer" must take "all reasonably practicable steps" to make arrangements for the person's release or leave, in consultation with the person, the person's carer (if he or she has one) and relevant agencies. No equivalent requirement applies in respect of forensic patients who are being released from a place other than a mental health facility

Question 14

Should a similar requirement be made in relation to forensic patients held in places other than mental health facilities? If so, how should it be framed?

Question 14

The Tribunal agrees that this would be a useful adjunct to the appropriate care of forensic patients held in a correctional setting. Indeed, the Tribunal is concerned that limiting term forensic patients receive very limited support in terms of planning for release into the community. It does however raise the issue of which agency would be responsible for that arrangement in a correctional setting.