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Subject: Submission to the Law Reform Commission review of the *Crimes (Sentencing Procedure) Act 1999*

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs) in NSW. CMOs provide a range of clinical, psychosocial, education and information resources and services with a focus on recovery orientated practice. MHCC's membership consists of over 250 CMOs whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health problems.

Working in partnership with both State and Commonwealth governments to promote recovery and social inclusion for people affected by mental illness, we participate extensively in mental health policy and sector development and facilitate linkages between government, non-government and private sectors. MHCC consult widely in order to respond to legislative reform and sit on national and state committees and boards in order to affect systemic change. MHCC also manage and conduct research projects and develop collaborative programs on behalf of the sector. We are a Registered Training Organisation delivering nationally accredited mental health training and professional development to the workforce.

MHCC welcome the opportunity to comment on the Law Reform Commission's preliminary review of the *Crimes (Sentencing Procedure) Act 1999.*

A review of over 60 surveys internationally examined the extraordinary prevalence of mental disorders in prisons across 12 countries and found that inmates present with substantially higher instances of major mental disorders, including psychotic disorders, major depression and anti-social personality disorders than are present in the general population (Fazel & Danesh, 2002).[1] Amongst these numbers are a large percentage of vulnerable people with comorbid disabilities such as acquired brain injury, cognitive and intellectual disability (many of whom are Aboriginal or Torres Islander people with complex trauma histories) which makes the increasing trend towards the use of imprisonment as a sentencing option a very poor solution to the problems surrounding recidivism.

Concerning Question 3 of the LRC preliminary outline, MHCC propose that the higher courts be provided with the same authority to divert people with disability as the local courts. Whilst the Compulsory Drug Treatment Program, MERIT and CREDIT as well as the other diversionary alternatives are shown to be encouraging alternatives to gaol they have limited application to people with complex needs and comorbid problems, especially intellectual

disability and mental illness. These people generally cycle back into goal or remain there because there is nowhere to release them to that can support their level of life skills and psychosocial disability and work with them to stay out of the criminal justice system (CJS).

ADHC currently has limited capacity to manage people with complex needs under its Integrated Services Program (ISP) however this program would need considerable expansion to meet the needs of people with complex needs in contact with the CJS. Competition for places within the program is high. A designated criminal justice ISP with 24/7 support until people can safely transition to lower levels of support may be necessary.

The LRC review asks whether there are: *any sentencing options in addition to those that currently exist that could be provided as an alternative to imprisonment, either generally, or in relation to particular categories of offenders.* MHCC fully support sentencing options that divert people out of the CJS especially for summary offences. Similarly, for people whose matters are before the higher courts who are assessed as people with mental illness and/or cognitive/ intellectual disability, specifically tailored services with highly trained and skilled personnel must be established to provide for their complex needs and level of risk. In fact as things stand, a judge may exercise discretion. Nevertheless, as often as not the judge has little opportunity to divert the person before them, as there are no services available. This is particularly problematic in rural and remote areas where even when diversion is possible it is usually to a metro area, resulting in community health care as well as carer, friend and family support mechanisms being disrupted.

Individual outcomes have been demonstrated to improve across most models of diversion (Ryan et al., 2010)[2] such as reduced justice system contacts, frequency and length of incarcerations, reduced psychiatric symptoms, less incidences of hospitalisation, reduced substance use, and increased work and residential stability. Results vary greatly depending on model design, legislative conditions, justice and health system resourcing, magistrate powers, education, and attitudes.

International scientific evaluations of diversion models are sparse and poorly executed (Hartford et al. 2007)[3] and many studies lack consistency in the definition of "effectiveness", which is usually stated to be the primary outcome. General outcome variables that are usually measured include: recidivism, compliance, monitoring/case management processes, and access to treatment/community services. Diversion programs are generally immature and do not accommodate for processes that are essential to establishing strong supporting evidence such as: control groups, longitudinal designs or standardised and objective data on key variables for comparison across jurisdictions.

Evidence is growing which shows that there is the opportunity to develop processes that deliver better outcomes for people with mental illness by utilising diversionary programs including:

- Increased likelihood that person with mental illness will have the chance to be assessed prior to a judicial hearing (pre-sentencing reports)
- Reduced recidivism
- Reduced length of incarceration for participants
- Improved mental health outcomes
- Increased cooperative relationship between criminal and mental health services - e.g., the recent experience with introducing mental health nurses in some NSW courts (Richardson, 2008).[4]

Obviously one essential criteria is that the individual is assessed to have or be at high risk of experiencing a diagnosable mental illness. Mental health diversion programs tend to first be

established for individuals booked for summary offenses, and there exists a diversity of opinion as to whether successful diversion programs could include 'net-widening' where either the current program is expanded to accommodate individuals charged with more severe offenses (felonies) or whether separate programs or lists are established for more sever or complex cases (e.g. coexisting conditions, including intellectual disability, acquired brain injury, substance abuse and personality disorders).

MHCC recommend that a network of clinicians/ mental health nurses be trained to work in all lower and higher courts, who can provide the skills and expertise necessary to assess people who present to court with symptoms of mental illness/ disorders, comorbid problems/ cognitive disabilities, etc. This does not translate into a recommendation for the establishment of a Mental Health Court in NSW, because our view is that a mental health court system perpetuates the ongoing engagement of people with mental illness/ co-morbid disabilities with the CJS when what we advocate is for a process enabling assessment to diversionary programs out of the CJS.

In remote areas where such assessments are problematic, i.e. in Burke it will be necessary to use current technologies, i.e., video-conferencing linking community workers (i.e., social workers, psychologists, OTs etc.,) in collaboration with the court/s to psychiatrists in the major centres.

We highlight at this point the necessity to establish a two-tier system that provides for 1) diversion into community mental health/ support services for people who have committed summary offences and pose no risk, and 2) a second tier that diverts people who have committed felonies into a program where their inclusion is compulsory and their progress is monitored by mental health professionals, rather than reporting back to a court.

MHCC strongly advocate moves towards the development of community alternatives for vulnerable people who are characteristically exposed to high risk of abuse in gaol. Vulnerable people, particularly people with intellectual disability fare much better in high needs supported community environments with case management models that fit the needs of the individual and allay community concerns. Costs to the tax payer are known to be less for community interventions than long-term incarceration or the revolving door and funding should be diverted into the development and expansion of community programs rather than increasing inmate numbers.

With regards to Question 4 in the preliminary outline, MHCC support the position that there is much scope for legitimate departure from the standard non-parole period in the *Crimes (Sentencing Procedure) Act 1999* which provides: "The reasons for which the court may set a non-parole period that is longer or shorter than the standard non-parole period are only those referred to in s 21A [of the Crimes (Sentencing Procedure) Act."

Although various aggravating and mitigating factors are listed in ss 21A (2) and 21A (3) respectively, s 21A (1) also permits consideration of "any other objective or subjective factor that affects the relative seriousness of the offence" and states that the matters specifically listed in the section are to be considered "in addition to any other matters that are required or permitted to be taken into account by the court under any Act or rule of law". In this MHCC propose that matters should be taken into account that relate to issues concerning third parties, particularly children who may for example be in foster care as a result of a custodial sentence. Similarly hardship to the offender should be considered as a result of protective custody, particularly if the individual is vulnerable to abuse in gaol, or is in poor mental and/or physical health.

As to Question 2: *the priority issues in sentencing law that require investigation and reform;*

apart from the matters already raised in Question 3, MHCC propose to make a further submission once the research and background papers are released on the four current projects listed below where the matters relate to people with mental illness/ cognitive and intellectual disability:

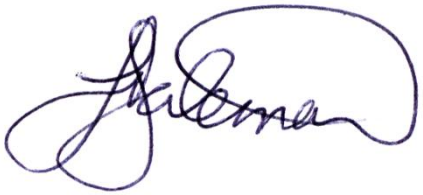
- *The use of non-conviction orders and good behaviour bonds*
- *Sentencing options for serious violent offenders*
- *The use of suspended sentences*
- *Standard non-parole periods and guideline judgments*

MHCC comment in relation to Question 1 is that the language of the Act itself could be simplified. It is currently less intelligible to the layman than many other pieces of legislation, i.e. The *NSW Mental Health Act 2007*. It would also be useful to have an 'Objects of the Act' describing the intention of the Parliament in the Act and connecting/ directing the user to other pieces of relevant legislation.

MHCC thanks the LRC for inviting us to contribute to this consultative process and express our willingness to provide further comment at the next stage of review.

For further comment on this submission please contact Corinne Henderson, Senior Policy Officer.

Yours sincerely



Jenna Bateman
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[1] Fazel, S. & Danesh, J. 2002.Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. Lancet, Vol. 359, pp. 545-550.

[2] Ryan, S.,Watanabe-Galloway, S., Brown, C. K. & Watanabe-Galloway, S. 2010.Toward Successful Postbooking Diversion: What Are the Next Steps? American Psychiatric Association: Psychiatry Services 61:469-477, May 2010.

[3] Hartford, K. 2007.People with Concurrent Disorders. Research Insights of the Regional Mental Health Care, London: St. Thomas Vol. 4, No.4 2007.

[4] Richardson, E. & McSherry, B. Mental health courts and diversion programs for mentally ill offenders: The Australian context. Paper presented at the IAFMHS Conference, Vienna 2008.